TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Steve Sacks MD

Respondent Name
Great Midwest Insurance Co

MFDR Tracking Number
M4-15-3307-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "this request was in response to a $175.91 reduction of the $1170.28 for the EMG performed on 6-19-14. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $175.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of the medical fee dispute was received however no position statement was submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2014	99204, 95886, 95913, A4556	$175.91	$147.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The carrier denied the disputed services with the following remittance codes:
   - RC 01– The charge for this procedure exceeds the amount indicated in the fee schedule
   - RC 15 – The provider charged for an initial visit on a subsequent date
   - RC AB – The payment for this service is bundled into payment of other services
   - TX 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- T193 – No additional reimbursement allowed after review of appeal/reconsideration

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on June 16, 2015. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

Findings

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the service in dispute as RC 15 – "The provider charge for an initial visit on a subsequent date." Review of the submitted documentation finds insufficient evidence to support this denial. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83.

   The services in dispute will be calculated as follows:

   - Procedure code 99204, service date June 19, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.43. The practice expense (PE) RVU of 1.99 multiplied by the PE GPCI of 0.916 is 1.82284. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.816 is 0.17952. The sum of 4.43236 is multiplied by the Division conversion factor of $55.75 for a MAR of $247.10. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $147.70.

   - Procedure code 95886, service date June 19, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 0.916 is 1.52972. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.816 is 0.03264. The sum of 2.42236 is multiplied by the Division conversion factor of $55.75 for a MAR of $135.05 at 4 units is $540.20.

   - Procedure code 95913, service date June 19, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3.56 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3.56. The practice expense (PE) RVU of 4.82 multiplied by the PE GPCI of 0.916 is 4.41512. The

malpractice RVU of 0.21 multiplied by the malpractice GPCI of 0.816 is 0.17136. The sum of 8.14648 is multiplied by the Division conversion factor of $55.75 for a MAR of $454.17.

- Procedure code A4556, service date June 19, 2014, has a status indicator of "P" or bundled service. No separate payment can be recommended.

3. The total allowable reimbursement for the services in dispute is $1,142.07. This amount less the amount previously paid by the insurance carrier of $994.37 leaves an amount due to the requestor of $147.70. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $147.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $147.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.